(HEAT QUESTIONNAIRE)

BWC LOGO

(Project Use Only - Corr4B)

mm/dd/yy

ADDRESSED TO:
(Injured worker/Employer)

Injured Worker:
Claim Number:
Injury Date:
Claim Type:

Employer Name:
Policy Number:
Employer Status:
MCO Name:
MCO Number:

The following information is necessary for us to complete the processing of this claim.

Claims for injuries caused by heat exhaustion, heat cramps, and other heat related injuries require additional information. Please answer the following questions and return this form to us within 14 days from the date of this letter. If we do not receive a response within this time, a decision will be issued based upon the evidence on file.

1. Did the injured worker's employment expose him/her to unusual artificial heat or intensified heat?

2. Did his/her work involve abnormal physical exertion?

3. State, if possible, the approximate temperature of artificial heat or how the natural heat was intensified.

_____ _____
Name (please print or type) Title

_____ _____
Company Address Telephone number

_____
City, State, Zip Code

1.3.2.6